Cover Page

***Confidential Quarterly Report Pursuant to KSA 65-4923(d)***

**Name of Facility**_____

**Address** _____

**Name & Title of Risk Manager**_____

**Phone number**_____ **Date:** _____

Please remember to complete and return the Cover Sheet along with the Quarterly Report.

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# KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT

Confidential Quarterly Report Pursuant to KSA 65-4923(d) HELP

**Please type or use a black pen when completing this form. Reports are due within *30 days***

**1. Type of facility [ ] Hospital [ ] Psychiatric Hospital [ ] Ambulatory Surgical Center [ ] Other_____**

**2. Year _____ Reporting quarter [ ] Jan-March [ ] April-June [ ] July-Sept. [ ] Oct.-Dec.**

**3. _____ Total number of incidents reported to the facility's risk management program this quarter.**

**4. *Final* standard of care determinations (SOCs) by the facility's risk management program this quarter:**

**a. _____ Total number of *final* SOC I (standard of care met) determinations**

**b. _____ Total number of *final* SOC II (standard of care not met, but with no reasonable probability of causing injury) determinations**

**c. _____ Total number of *final* SOC III (standard of care not met with injury occurring or reasonably probable) determinations**

**d. _____ Total number of *final* SOC IV (possible grounds for disciplinary action by the appropriate licensing**

**Sum of 4c and 4d =**

**5. Specify the number of reports sent to each of the following licensing agencies (*total must equal sum of Items 4c & d)*:**

**____Board of Healing Arts ____Board of Nursing ____Board of Pharmacy ____Other (Specify)_____**

**____ KS Department of Health and Environment Total: ____ (When reporting an adverse finding to KDHE, please include the following data in letter form: Incident number, date of occurrence, description of the incident, issues, SOC, rationale for the SOC, provider identification and action/recommendations taken).**

***SOC III & IV only* - Types of incidents/occurrences (medication error, surgical error, falls, etc.) reported**

**6. Specify the number of corrective actions taken for each report listed in Item #5 above:**

| Number | Type of Corrective Action Taken | Number | Type of Corrective Action Taken |
|---|---|---|---|
| | Pending | | Policy/procedure change |
| | Suspension of privileges | | Termination of employment |
| | Counseling/education | | Restriction of privileges |
| | Revocation of privileges | | Other (specify) |

**Part 2 - Other Side**

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**Part 2 - Quarterly Report**

**NOTE: Completion of Items 7. and 8. is optional.** Please see instructions for additional information.

**7. Identify any positive changes that your facility has implemented that relates to or has been shown to prevent or reduce medical errors or improve patient safety.**

**8. What improvement has been noted as a result of that change?**

Return this report **along with the Cover Sheet** to:

Risk Management Program
Bureau of Child Care and Health Facilities
Kansas Department of Health and Environment
1000 SW Jackson Street, Suite 200
Topeka, Kansas 66612-1365

**QR/RM 06/2004**

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